STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/24/20 to 2/27/20. Also reviewed in the course of the survey was complaint intake WY00002968. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set mg- milligrams RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and resident interview, the facility failed to ensure the MDS assessment was accurate for 1 of 12 sample residents (#19) reviewed. The findings were: Review of the quarterly MDS assessment dated 1/8/20 showed resident #19 had a stage 2 pressure injury. Interview with the resident on 2/25/20 at 9:57 AM revealed the resident denied any sores or open injuries. Interview with RN #1 and RN #2 on 2/26/20 at 11:21 AM revealed resident #19 had never had a pressure injury at	F 641	Facility failed to meet the requirements of F tag 483.20, Accuracy of Assessments as evidenced by inaccurate MDS assessment that reflected a pressure ulcer for resident #19, who had no pressure ulcers. To correct that deficiency, the facility corrected and submitted a modification for the quarterly assessment for that resident on 03/15/2020. All other MDS□s completed in the last quarter, for each resident, were reviewed. That task was completed on 03/10/2020.	3/20/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/2020

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F 641	Continued From page 1 any time. Interview with the DON on 2/26/20 at 11:23 AM revealed the resident had never had a pressure injury and the expectation was the entry in the MDS assessment would reflect that.	F 641	One other resident had an inaccuracy in the MDS, and that assessment will be corrected and submitted by 03/20/2020. To prevent future inaccuracies, the MDS coordinator will communicate significant changes i.e. presence of a pressure ulcer, incontinence where there was none previously to the Director of Nursing. The director of nursing will then confirm or deny the changes. The skin assessments for anyone reported to have a stage II or higher will be audited by the DON for accuracy and the audit will be reported on as a function of QAPI.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		3/20/20

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F 761	Continued From page 2 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a secure pharmacy storage area for 1 of 1 medication storage rooms. The findings were: Observation on 2/25/20 at 8:23 AM showed the medication storage room door standing open with no nursing staff in attendance. A sign on the door stated "PLEASE LEAVE THIS DOOR CLOSED UNLESS OCCUPIED." Further observation on 2/26/20 at 10:29 AM showed the medication storage room door open with no nursing staff in attendance. Interview with RN #1 on 2/27/20 at 8:48 AM revealed the facility rules required the door to the medication storage room be closed and locked when nursing staff was not present. Interview with the DON on 2/27/20 at 9:21 AM revealed the facility expectation was the door of the medication room be closed and locked when staff was not present.	F 761	The facility failed to meet the requirements of F tag 483.45, Label/Store Drugs and Biologicals as evidenced by an open door to the medication room despite signage notifying staff that the door is to remain shut. To correct the deficiency, nurses were educated on 03/06/2020 regarding the importance of keeping the medication room door shut. Further, a "closer" fitting was ordered and will be installed on or before 03/20/2020. This device will force closure for the medication room door. Repeat education for nurses regarding the importance of keeping the medication room door shut will occur at the nursing meeting on 03/31/2020. The director of nursing will audit door closures for the next 90 days to ensure the newly installed device is functioning properly and will report as a function of QAPI.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		3/6/20

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F 880	Continued From page 3	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 4 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff utilized infection prevention techniques to aid in the prevention of urinary tract infections for 1 of 5 sample residents (#21) with a catheter. The findings were: Observation on 2/25/20 at 9:11 AM showed the urinary catheter bag for resident #21 lying on the floor next to the recliner. The catheter bag did not have a secondary bag or covering to protect it. Interview on 2/26/20 at 1:25 PM with the infection control nurse revealed the facility expectation was that the catheter bag not be placed on the floor without a protective barrier, and the expectation was the bag be suspended from the chair or side of the bed. It was further revealed the CNA training for handling and care of catheter bags was done annually during the	F 880	The facility failed to meet the requirements of F tag 483.80 (a)(1)(2)(4)(e)(f) Infection Prevention and Control as evidenced by a resident□s Foley catheter bag on the floor, without proper covering. To correct that deficiency, staff ensured a bag was placed around the catheter for resident #21 on 02/27/2020. An audit of all other residents wearing catheters was conducted and found no further issues. Education was provided to staff on 03/06/2020 regarding the need for covers on all Foley catheter bags. The facility will request night shift C.N.A□s to check all catheters for bag placement on last rounds. The C.N.A manager will review audits and report findings as a function of QAPI.	

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F 880	Continued From page 5 monthly training meetings.	F 880		